ARIZONA DEPARTMENT OF HEALTH SERVICES, OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
TBI/SCI/CYSHCN BILLING AND INVOICE PACKET
TBI DIRECT CARE SERVICES DETAIL REPORT
CONTRACTOR NAME: **ADHS PO#**
ADHS CONTRACT # **State Fiscal Year 2008**
BILLING MONTH: **DATE:**

1	2	4	5	6		7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
	MEMBER INFORMATION						REFERRALS TO OTHER PAYERS					APPROVED DIRECT CARE SERVICES				APPROVED DIRECT CARE SERVICES				APPROVED DIRECT CARE SERVICES				APPROVED DIRECT CARE SERVICES				APPROVED DIRECT CARE SERVICES				APPROVED DIRECT CARE SERVICES				
FRC Name	Member Name	Referral Date	Sex	DOB	Type of Health Insurance	Insurance or AHCCCS #	Referred Health Plan	Services Requested	Status	Planned Start Date	Reason for denial or delay	Type of Services	# Of Units	Total Cost	Cost per Unit	Type of Services	# Of Units	Total Cost	Cost per Unit	Type of Services	# Of Units	Total Cost	Cost per Unit	Type of Services	# Of Units	Total Cost	Cost per Unit	Type of Services	# Of Units	Total Cost	Cost per Unit	Type of Services	# Of Units	Total Cost	Cost per Unit	TOTAL